Medicaid ID #: _____
Date of Assessment:_____
Type: Open Card or Fee For Service_____ Managed Care (MHP):_____
Non-Medicaid:
☐ Application in process. Explain_____
☐ Not yet applied. Explain _____

Location: ☐ Home Visit ☐ Other Visit ☐ Office Visit

Has the consent form been signed? ☐YES ☐NO

Maternal Support Services
INITIAL ASSESSMENT

GENERAL INFORMATION

Beneficiary's First Name _____ Last Name _____ Date of Birth ____/_____/____

Phone Number _____(hm) _____(wk) Best time to reach Beneficiary _____

Is there another phone number where you can be reached?_____

Current Address _____
Street Address City Zip County

Directions
_____

_____

Are you?
☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Separated ☐ Cohabiting

Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Work First ☐ Not Working ☐ Student

Last Grade Completed _____ Race/Ethnicity _____
What language do you prefer to speak? _____
What language do you prefer to use for reading?_____

Name of Father of Baby (FOB)_____Date of Birth ____/_____/____ Race/Ethnicity_____
Employment Status: ☐ Full Time (FT) ☐ Part Time (PT) ☐ Not Working ☐ Student
Relationship with Mother: ☐ Involved ☐ Not Involved

Household Roster (List name of all members)*	Relationship to Beneficiary	Sex	Race/Ethnicity	Age

*Include husband/partner if different than above; Mother of Baby (MOB) parents/FOB parents; MOB siblings/FOB siblings; MOB other children.

Beneficiary's Name: _____

HEALTH INFORMATION

MATERNAL HEALTH

1. Do you have a prenatal care provider that accepts Medicaid? ☐ YES ☐ NO
   If no, what kind of problem have you had in selecting a provider? _____
   _____
2. Have you had a prenatal visit with a prenatal care provider? ☐ YES ☐ NO
   a. Name of prenatal care provider _____
   b. Address/Location_____
   c. How many weeks or months pregnant were you on your first visit for prenatal care?_____
3. Did you get prenatal care as early as you wanted? ☐ YES ☐ NO
   If no, check all that apply:
   - ☐ no one to take care of your children
   - ☐ had no way to get to the clinic or office
   - ☐ could not get a doctor or nurse to take you as a patient
   - ☐ could not get an appointment earlier
   - ☐ other _____
   - ☐ did not think you were pregnant
   - ☐ did not have enough money or insurance to pay for visits
   - ☐ did not have your Medicaid card
   - ☐ did not know where to go
4. Are you satisfied with the prenatal care you are receiving now? ☐ YES ☐ NO
   If no, check all the items below that you are not satisfied with:
   - ☐ amount of time you had to wait to see the prenatal care provider
   - ☐ amount of time the doctor or nurse spent with you during your visits
   - ☐ advice you received on how to take care of yourself
   - ☐ hours the office or clinic was open
   - ☐ understanding and respect the staff showed towards you as a person
5. What is your due date?_____If unknown, when did your last menstrual period start?_____
6. Do you have any health problems?_____
   _____
7. Previous Pregnancies:
   a. How many pregnancies have you had before this one?_____ How many living children?_____
   b. How many stillbirths (fetal deaths)?_____ miscarriages?_____ abortions?_____
   c. Have any of your children had a birth defect? ☐ NO ☐ YES
      If yes, please explain_____
      _____
   d. Did you have any complications with any previous pregnancy? ☐ NO ☐ YES
      If yes, please explain_____
      _____
   e. Did you have a six-week check-up (postpartum) after your last pregnancy? ☐ YES ☐ NO
8. Family Planning:
   a. Were you using birth control when you became pregnant with this child? ☐ YES ☐ NO
      If no, do you consider this a wanted pregnancy? ☐ YES ☐ NO
      If no, do you need help with making decisions about completing this pregnancy? ☐ NO ☐ YES
   b. What do you want to use for birth control after your baby is born?_____
9. Dental Health:
   a. Do you currently have a dentist? ☐ YES ☐ NO
   b. When was the last time you saw a dentist? _____
   c. Do you currently have any dental problems? ☐ NO ☐ YES
   d. Do your children have any dental problems? ☐ NO ☐ YES

SMOKING

1. Do you currently smoke cigarettes? ☐ NO ☐ YES
   a. How many cigarettes do you smoke a day? _____
   b. Have you cut down? ☐ YES ☐ NO
   c. Have you/are you seriously considering quitting? ☐ YES ☐ NO
2. Have you ever smoked? ☐ NO ☐ YES
   a. When did you stop smoking? _____
3. Do you plan to stay a non-smoker:
   a. During this pregnancy? ☐ YES ☐ NO
   b. After this pregnancy? ☐ YES ☐ NO
4. Do others smoke around you inside your home? ☐ YES ☐ NO
5. Do fellow workers smoke around you on the job? ☐ YES ☐ NO

Beneficiary's Name: _____

IMMUNIZATIONS

1. Have you been immunized against any of the following infections?
   ☐ Chicken Pox ☐ Hepatitis B ☐ Measles ☐ Meningitis ☐ Mumps ☐ Rubella ☐ Don't Know
2. Have you ever been around anyone with these infections in the last month? ☐ NO ☐ YES
3. Are the immunization records on all preschool children in the household available? ☐ YES ☐ NO

NUTRITION

1. What was your weight just before this pregnancy? _____ Current weight? _____ Height? _____
2. How much weight would you like to gain with this pregnancy? _____
3. Have you had any of the following problems?
   ☐ change in appetite ☐ constipation ☐ diarrhea ☐ food allergies ☐ heart burn ☐ nausea ☐ vomiting
4. What changes have you made in eating since you found out you are pregnant?_____
   a. Are you on a special diet? ☐ NO ☐ YES
      If yes, please describe _____
   b. Are you able to drink milk and eat milk products? ☐ YES ☐ NO
   c. Do you feel the need to eat any non-food, such as ice, clay, starch, etc.? ☐ YES ☐ NO
      If yes, what_____
   d. Have you ever had an eating disorder, such as bulimia or anorexia nervosa? ☐ NO ☐ YES
      If yes, please explain _____
   e. How often do you eat fast foods in a week? _____
   f. How many pops/Kool-aid do you drink in a day? _____
   g. How many cups of coffee/tea do you drink in a day? _____
   h. How many glasses of water do you drink in a day? _____
   i. Describe a typical day's meals: _____
      _____
5. Do you have enough food for three meals a day? ☐ YES ☐ NO
   a. Do other family members have enough food? ☐ YES ☐ NO
   b. Are you currently enrolled in WIC? ☐ YES ☐ NO
   c. Do you receive food stamps? ☐ YES ☐ NO
   d. What other resources do you have for food?_____
6. Are you taking a prenatal vitamin daily? ☐ YES ☐ NO
   a. Are you taking herbal supplements? ☐ NO ☐ YES
7. Breast-Feeding
   a. Are you planning to breast-feed this baby? ☐ YES ☐ NO
   b. What concerns do you have about breast-feeding? _____
      _____

SEXUALLY TRANSMITTED INFECTIONS

1. Have you or your partners been treated with blood products prior to 1985? ☐ NO ☐ YES ☐ Don't know
2. Have you or someone you've had sex with used needles to take drugs? ☐ NO ☐ YES ☐ Don't know
3. Have you had more than one sex partner? ☐ NO ☐ YES
4. Have you had sex without using a condom in the last 12 months? ☐ NO ☐ YES ☐ Don't know
5. Have you had or been treated for any of the following STIs?
   ☐ Chlamydia ☐ Genital Warts ☐ Gonorrhea ☐ Hepatitis B ☐ Herpes ☐ Syphilis ☐ Trichomoniasis
6. Has your current partner or father of the baby ever had a STI? ☐ NO ☐ YES ☐ Don't know
7. Have you had a test for HIV during this pregnancy? ☐ YES ☐ NO
8. Would you like more information on HIV? ☐ YES ☐ NO

EMOTIONAL/ MENTAL HEALTH INFORMATION

MENTAL STRESS

1. Are you a first-time parent? ☐ NO ☐ YES
   a. What are your concerns about being a parent? _____
2. How does your partner feel about this baby? _____
3. Is your partner the father of the baby? ☐ YES ☐ NO
   a. If no, what is your current relationship with the father of the baby? _____

Beneficiary's Name: _____

4. Who can you depend on when you need help or someone to talk to? _____

5. Have you felt isolated during this pregnancy? ☐ NO ☐ YES
   If yes, please describe _____

6. Are there issues now that are particularly stressful? ☐ NO ☐ YES
   If yes, please describe _____
   a. How do you normally cope with stress? _____
   b. Have you experienced any recent losses (i.e., death, stillbirth, miscarriage, job)? ☐ NO ☐ YES
      If yes, please describe _____

7. Depression
   a. Have you had any of these feelings since being pregnant?
      ☐ Depressed mood ☐ Loss of interest in usually pleasurable activities ☐ Difficulty concentrating or making decisions
      ☐ Fatigue ☐ Changes in appetite or sleep ☐ Recurrent thoughts of suicide ☐ Feelings of worthlessness or guilt
      ☐ Excessive anxiety
   b. Have you ever been diagnosed with a mental illness by a health professional? ☐ NO ☐ YES
      If yes, are you currently taking medications for this illness? ☐ NO ☐ YES
      If yes, are you currently seeing a mental health counselor? ☐ NO ☐ YES
8. Have you or a family member been involved with Children's Protective Services (CPS)? ☐ NO ☐ YES
9. Domestic Violence – Since you have been pregnant
   a. Has your partner pushed, hit, slapped, kicked, choked or physically hurt you in any way? ☐ NO ☐ YES
   b. Has anyone else physically hurt you in any way? ☐ NO ☐ YES
   c. Within the last year, has anyone forced you to have sexual activities? ☐ NO ☐ YES
      If yes, who_____
   d. Are you fearful of your safety at this time? ☐ NO ☐ YES
10. Have you ever received counseling and sought other resources? ☐ NO ☐ YES

ALCOHOL/ DRUG USE

1. Alcohol
   a. During the three months before you became pregnant, how many alcoholic drinks did you have in an average week? (A drink is one glass of wine, one wine cooler, one can or bottle of beer, one shot of liquor, or one mixed drink.)
      ☐ did not drink then ☐ less than one drink per week ☐ 1- 3 drinks per week ☐ 4-6 drinks per week
      ☐ 7-13 drinks per week ☐ 14 or more drinks per week ☐ don't know
   b. During the three months before you became pregnant, how many times did you drink five or more alcoholic drinks in one setting?
      ___ times ☐ did not drink then ☐ don't know
   c. Since you became pregnant, how many alcoholic drinks have you had in an average week?
      ☐ do not drink now ☐ less than one drink per week ☐ 1- 3 drinks per week ☐ 4-6 drinks per week
      ☐ 7-13 drinks per week ☐ 14 or more drinks per week
   d. Since you became pregnant, how many times have you drunk five or more alcoholic drinks in one setting?
      ___ times ☐ don't drink now ☐ don't know
2. Drug
   a. Which of the following prescription medications do you take now? (Check all that apply.)
      ☐ allergy medication ☐ antibiotics ☐ antiseizure ☐ vitamins
      ☐ Demerol, morphine ☐ sleeping pills ☐ hormones ☐ diet pills or amphetamines
      ☐ pain killers ☐ steroids ☐ Methadone ☐ antidepressants or mood regulators
      ☐ other prescribed medications_____
   b. Some mothers tell us that the stress of their pregnancy is so high they use street drugs while they are pregnant. Which of these recreational or street drugs have you taken during this pregnancy?
      ☐ Crack ☐ Cocaine ☐ Heroin ☐ Marijuana or Hashish
      ☐ Methadone ☐ PCP, angel dust, LSD ☐ Speed/Uppers
      ☐ Other_____
   c. Have you ever been arrested due to drugs or alcohol use? ☐ NO ☐ YES
      If yes, please describe_____

Beneficiary's Name: _____

ENVIRONMENTAL INFORMATION

1. What is your current housing situation? (Select all that apply.)
   ☐ House-own ☐ Apartment ☐ Live with FOB ☐ Shelter ☐ Friend
   ☐ House-rent ☐ Live with SO (not fob) ☐ Migrant Housing ☐ Relative ☐ Rent
   ☐ Live with parents ☐ Homeless ☐ Other

2. Is your current housing:
   ☐ built before 1950 ☐ remodeled/renovated in the last year ☐ near an industrial plant, dump site
3. Does your house (or frequently visited home) have peeling or chipping paint? ☐ NO ☐ YES
4. Does your house (or frequently visited home) have a lot of dust and mold? ☐ NO ☐ YES
5. Was asbestos insulation used on pipes or hot water tank or for insulation in attic/walls? ☐ NO ☐ YES
6. Does anyone in your household work around lead (pottery, automobile repair, plumbing)? ☐ NO ☐ YES
7. Do you regularly (at least weekly) use cleaners for glass, oven, floors, glues, solvents, paint strippers? ☐ NO ☐ YES
8. Do you currently use pesticides (bug or weed killer, flea or tick spray) in the home? ☐ NO ☐ YES
9. What is the source of your drinking water? ☐ well ☐ city ☐ store bought
10. Are the following in good working order? ☐ furnace ☐ plumbing ☐ refrigerator ☐ stove
11. Do you have a working smoke detector? ☐ YES ☐ NO
    Last time checked?_____
12. Does anyone in your household:
    a. Smoke? ☐ NO ☐ YES
    b. Use a wood stove? ☐ NO ☐ YES
13. Do you have guns and/or weapons in your home? ☐ NO ☐ YES
14. How many times have you moved in the past year? _____ Why? _____
15. Are you having any housing problems at this time? ☐ NO ☐ YES
    If yes, please describe _____
16. Are you having problems paying bills at this time? ☐ NO ☐ YES
    If yes, ☐ rent/mortgage ☐ gas ☐ electric ☐ phone
    More description _____
17. Do your child/children have a car seat? ☐ YES ☐ NO
    If yes, is the car seat ☐ new ☐ used
    a. Have you been shown how to install the seat in your vehicle? ☐ YES ☐ NO
18. Do you have a crib for your new baby? ☐ YES ☐ NO
19. Do you need help getting baby items? ☐ NO ☐ YES

CHILDBIRTH EDUCATION CLASSES (CBE)

1. Are you nervous about going through the labor and delivery process? ☐ NO ☐ YES
   If yes or no, explain: _____
2. Who will be taking you to the hospital when you are in labor? _____
3. Who will be your coach/with you during delivery? _____
4. Have you ever taken a CBE class? ☐ YES ☐ NO
5. Do you plan to take a CBE class? ☐ YES ☐ NO
6. Will there be a problem getting to the class? ☐ NO ☐ YES

KEEPING MEDICAL APPOINTMENTS (TRANSPORTATION)

1. How do you usually get to healthcare appointments (e.g., doctor's office, WIC, lab, pharmacy, etc.)? _____
2. Do you drive? ☐ YES ☐ NO
3. Do you have access to a reliable vehicle? ☐ YES ☐ NO
4. Do you have any concerns with keeping your increased appointments due to the pregnancy? _____
5. If you know, what is the maximum distance you will have to travel to keep your appointments? _____
6. If you are in a Medicaid Health Plan, have they ever helped you to get to the doctor's office? ☐ YES ☐ NO

Beneficiary's Name: _____

SUMMARY

BENEFICIARY SUMMARY

1. Do you understand what the MSS program is about? ☐ YES ☐ NO
2. What do you want the MSS team to work with you on? _____
3. Do you foresee any problems keeping appointments with the MSS team? ☐ NO ☐ YES
   What kind? _____

CLINICIAN ASSESSMENT SUMMARY

Strengths:

Weaknesses:

Referrals Made:

I have provided a copy of the following MSS program information:

☐ Beneficiary grievance policy/procedure

☐ Medical and non-medical emergency options

MSS assessment form completed by:

Signature Discipline Date